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Communication study

Respecting patients is associated with more patient-centered communication behaviors in clinical encounters

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ABSTRACT

Objective: Attitudes towards patients may influence how clinicians interact. We investigated whether respect for patients was associated with communication behaviors during HIV care encounters.
Methods: We analyzed audio-recordings of visits between 413 adult HIV-infected patients and 45 primary HIV care providers. The independent variable was clinician-reported respect for the patient and outcomes were clinician and patient communication behaviors assessed by the Roter Interaction Analysis System (RIAS). We performed negative binomial regressions for counts outcomes and linear regressions for global outcomes.
Results: When clinicians had higher respect for a patient, they engaged in more rapport-building, social chitchat, and positive talk. Patients of clinicians with higher respect for them engaged in more rapport-building, social chitchat, positive talk, and gave more psychosocial information. Encounters between patients and clinicians with higher respect for them had more positive clinician emotional tone [regression coefficient 2.97 (1.92–4.59)], more positive patient emotional tone [2.71 (1.75–4.21)], less clinician verbal dominance [0.81 (0.68–0.96)] and more patient-centeredness [1.28 (1.09–1.51)].
Conclusions: Respect is associated with positive and patient-centered communication behaviors during encounters.
Practice Implications: Clinicians should be mindful of their respectful attitudes and work to foster positive regard for patients. Educators should consider methods to enhance trainees' respect in communication skills training.

1. Introduction

Communication training of health professionals emphasizes the acquisition of specific skills, yet attitudes towards patients may also influence how healthcare practitioners interact. An attitude of respect towards patients is placed at the center of bioethics and medical professionalism, and can be understood as having both a cognitive or emotional component (a belief intrinsic within a clinician that the patient has value) and a behavioral component (acting on this belief with observable behaviors) [1]. Prior studies have found that respectful clinician communication behaviors as reported by patients are associated with improved patient adherence to therapeutic regimens [2,3] and improved health outcomes in chronic disease management [4–8]. When patients feel "known as a person" by their HIV care clinician, they are more likely to receive antiretroviral therapy (ART), adhere to ART, and have undetectable HIV viral loads [9]. Although being known as a person is not a measure that specifically uses the word, 'respect', it evokes the essence of respect as acknowledgment of the patient as a person. From the patient perspective, PLWH who report that their clinician always treats them with dignity and respect are also more likely to keep their clinic appointments [10].

The extent to which better patient experiences represent more respectful attitudes on the part of clinicians is unclear, in part

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because such attitudes can be challenging to measure and far fewer studies have attempted to do so. In the primary care context, one study found that respect for particular patients varied and was associated with more positive clinician communication behaviors [11]. These findings have not been replicated until now. Furthermore, clinician respect for patients may be particularly relevant in HIV care due to several factors such as racial/ethnic differences between patients and clinicians [12–19], HIV-related stigma [20–22], and stigma towards substance use disorders [23–25]. Patients with active substance abuse perceive less respect from clinicians and demonstrate less engagement in HIV care [10].

No prior studies have assessed clinicians' respect for patients with HIV or the observable clinician behaviors that convey respect to patients. To address this gap, we aimed to investigate whether clinician-reported respect for patients varied with patient or clinician characteristics and whether respect was associated with communication behaviors during clinical encounters. This understanding is needed to inform efforts of optimize patient–clinician relationships, in HIV care and beyond.

2. Methods

2.1. Study design, subjects, and setting

We conducted a cross-sectional analysis of data from the Enhancing Communication and HIV Outcomes (ECHO) Study, which was designed to assess possible racial/ethnic disparities in communication in HIV care and to determine which interactions are associated with more positive outcomes among patients with HIV [12–13,26–29]. Study subjects were HIV care practitioners and patients at four HIV outpatient sites in the United States (Baltimore, Detroit, New York, and Portland). The study received IRB approval from each of the four sites. Eligible clinicians were physicians, nurse practitioners, or physician assistants who provided primary HIV care to patients at one of the study sites. Eligible patients were HIV-infected; age greater than 18; English-speaking; and had had at least one prior visit with their clinician.

2.2. Data collection

Clinicians who agreed to participate gave informed consent and completed a baseline questionnaire. Research assistants then approached patients of participating clinicians in the waiting rooms, with the goal of enrolling 10 patients per clinician. Eligible patients gave informed consent, and then research assistants placed a digital audio-recording device in the examination room to record the patient–clinician encounter. Following the encounter, patients completed a one-hour interview with research assistants and reported demographic, social, and behavioral characteristics. Clinicians also completed post-encounter questionnaires, including assessment of clinician-reported respect for the patient in the encounter.

3. Measures

3.1. Clinician respect

The independent variable was clinician-reported respect for that particular patient assessed immediately following the encounter with the item, "Compared to other patients, I have a great deal of respect for this patient" (5-point Likert scale from strongly agree to strongly disagree). Responses were dichotomized to compare those who strongly agreed/agreed (higher respect) with those who were neutral or disagreed (lower respect). This measure has been used in prior studies in primary care to assess healthcare practitioners' respect for patients [11,30].

3.2. Communication behaviors

The outcomes were clinician and patient communication behaviors assessed by the Roter Interaction Analysis System (RIAS), a widely used coding system to assess patient and clinician communication behaviors with well-documented reliability and predictive validity [4,5,31,32]. RIAS analysts assign one of 37 mutually exclusive and exhaustive categories to each complete thought expressed by either the patient or clinician (referred to as an utterance). Four broad types of exchange can be assessed by combining these categories to reflect socio-emotional communication (including explicitly emotional talk such as empathy and concern, positive talk including agreements, approvals and compliments, negative talk such as criticisms and disagreements, and social chit-chat), information-giving (including biomedical and psychosocial/lifestyle information), question-asking (including open-ended and closed-ended questions), and patient activation (such as asking for the others' opinions, confirming the others' understanding, or clarifying one's own understanding and cues of interest). The combined category of rapport-building is calculated from summation of all utterances by the clinician (and separately, by the patient) in the sub-types of empathy, legitimation, partnership, reassurance, and humor.

In addition, the RIAS provides global ratings of the patient and clinician emotional tone. Emotional tone scores are calculated by summing coders' subjective ratings for patients and clinicians (separately) on several dimensions. The patient emotional tone is the sum of coders' ratings of patient dominance/assertiveness, friendliness/warmth, responsiveness/engagement, and sympathy/empathy exhibited by the patient during the encounter. The clinician emotional tone is the sum of coders' ratings of clinician interest/attentiveness, friendliness/warmth, responsiveness/engagement, and sympathy/empathy, reverse-coded for the degree to which the clinician was hurried/rushed. Inter-coder reliability, calculated on a random sample of 41 audio files, was greater than 90% agreement in each of the domains.

Summary measures for the encounters included verbal dominance, calculated as the ratio of clinician utterances to patient utterances, and patient-centeredness, calculated as the ratio of psychosocial/emotional utterances to biomedical utterances. Total visit length for the encounters was also recorded from the audio files.

3.3. Covariates

Covariates included patient and clinician demographics and length of patient–clinician relationship. Patient interviews provided socio-demographic information (age, sex, employment, and IV or illicit drug use). Medical records provided data on patient CD4 counts and HIV viral loads. Clinician baseline questionnaires provided self-reported clinician demographic information such as age, sex, and race/ethnicity.

3.4. Statistical analysis

We used chi-squared and *t*-test analyses to investigate associations between clinicians' respect for patients and patient or clinician characteristics. Two types of communication outcomes were analyzed: (1) counts of patient or clinician behaviors (e.g. utterances of rapport-building, utterances of information-giving) and (2) global measures (e.g. patient or clinician emotional tone, clinician verbal dominance in the entire encounter). To examine associations between clinician respect and counts outcomes, we performed negative binomial regressions. To examine associations between clinician respect and global outcomes, we performed linear regressions with identity link. For both types of analysis, we